APPENDIX C

QUESTIONS FOR OFFERORS

APPENDIX C

QUESTIONS FOR OFFERORS

GENERAL QUESTIONNAIRE

Organization Name:

Location of Home Office:

Primary Contact:

Address:

City/State/Zip:

Telephone: _____FAX: _____

A. General Information

1. Designate the individual(s) representing your organization during the proposal process and who will be assigned overall responsibility for the contract (attendance at meetings, etc.). Include the name, title, and address of each individual, along with a brief description of qualifications and experience.

2. What account management services (meetings, teleconferences, etc) do you provide to large clients and their consultants?

3. Provide a brief biography of the proposed service representative.

4. Describe your organization's philosophy, objectives and future plans regarding claim office issues such as:

   a. Plans to move the claim office

   b. Office size and locations.

5. Indicate the location of the office(s) that will:

   a. Process claims

   b. Process premium statements.

6. Briefly describe what distinguishes your organization in the marketplace.

7. Provide references from three current and three former clients. If possible, include clients that are or were served by the service representative who will be assigned to the EUTF. Be sure to include a name and telephone number for a person that we may contact at each client reference. For each category of benefits for which an offeror is submitting a proposal, the offeror should provide a list of large clients (over 1,000 employees) that it currently serves. Clients in Hawaii should be listed first.

8. Provide samples of your communication materials, including I.D. cards, enrollment forms, summary plan descriptions, claim forms and explanations of benefits in the **Samples Section**.

9. List and describe your standard reports. Include samples of these in the **Samples Section**.

10. List and describe optional reports available and your ad hoc reporting capabilities. Please include the cost of additional reports, if applicable. Include samples in the **Samples Section**.

11. Are any networks solely owned and operated by your organization? If not, explain the contractual relationship you have with outside parties. Are your provider contracts based on exclusive arrangements? Include any leasing arrangements currently in effect.

12. Are there any outstanding legal actions pending against your organization? If so, please explain the nature and current status of the action(s). What fidelity and surety insurance or bond coverage do you carry to protect your clients? Specifically describe the type and amount of the fidelity bond insuring your employees, which would protect the plan(s) submitted in your proposal in the event of a loss. Do you agree to furnish a copy of all such policies for review by legal counsel if requested?

13. If your benefit payments are based on eligible charge, eligible fee or charge, your proposal shall define terms such as: "eligible charge," "eligible fee," "charge," "usual fee," "usual and customary fee," "customary fee" and "reasonable fee."

14. Are you subcontracting any services? If "yes", indicate which services and how such services are paid.

15. List any current accreditations.

16. Do you agree to notify the EUTF immediately if you lose any accreditation, license, liability insurance coverage or bonding?

17. Do you currently conduct satisfaction surveys? If so, provide a copy of the latest results in the **Sample Section**. Does an outside organization perform the survey?

18. Are you willing to conduct satisfaction surveys for the EUTF at no additional charge?

19. Does your telephone system calculate the time it takes for a live person to answer each call?

    a. If so, does that time to answer stop the instant a person speaks to a caller, even if the caller is immediately put on hold?

    b. Does your telephone system track the number of calls that are abandoned before they can be answered?

B. Financial Information

20. Provide the last three years audited financial statements and auditor's report.

21. For insured proposals, please include copies of the most recent reports on your organization's claim paying ability from the rating services, such as Standard & Poors, Moody's, Duff & Phelps and A. M. Best. If you are not rated by any of these organizations, please state so.

22. For insured proposals, has there been any change in your ratings in the last three years? If yes, please explain the nature and reason(s) for the change.

23. List all interest charges and/or credits; the rate of interest credited; how the amount on which interest is charged or credited is calculated; and, the basis of your interest rate. (Please note: the interest rate chargeable to the EUTF is capped by statute.)

24. Are there any charges made by your organization, or any other sub-contractor, for any item not mentioned by you in your retention illustration (question 28 below) or in response to the questions above? If yes, provide a detailed description of the item(s) and your charge for them.

25. Under insured proposals, do you establish incurred-but-not-paid reserves on the basis of a percentage of premium, of paid claims, actual lag studies on that policy or do you use some other method? Please explain the methodology used and indicate whether there is any change in the way reserves are set between the first and subsequent policy years.

26. Under insured proposals, is there any provision in your experience rating or dividend calculation methodology for establishing any reserve other than an incurred-but-not-paid reserve? Can such a reserve be established without the advance written consent of the EUTF? If so, please indicate the specific basis upon which such reserve(s) is determined. If these reserves are optional, please explain the basis upon which they would be recommended. Include in your answer the following information:

    a. The instances under which your organization will have the right to draw from this reserve; and;

    b. The provisions for the return of this reserve upon cancellation of the policy.

27. Describe any limit on deficit carry forwards.

28. For both insured proposals and proposals for administrative services, state your retention amount as a fixed monthly dollar amount per eligible employee regardless of family size. Provide a breakdown of your retention as to what it consists of, i.e., taxes, claims processing, risk charge, administrative, etc.

    An offeror who is required, under Chapter 431:7, HRS, to pay a premium tax, to the State of Hawaii, should show the percent or amount as a separate charge in addition to other retention charges. The offeror shall state what the retention charges (state premium taxes and all other charges) are as a percent or amount of the total premium. Should an

offeror, governed by Chapter 431:7, HRS, be awarded the contract, offeror may increase its premium during the term of the contract by any increase in the premium tax.

PPO/DUAL-COVERAGE/TRICARE SUPPLEMENT/HIGH DEDUCTIBLE HEALTH PLAN QUESTIONNAIRE

The EUTF is requesting proposals for Preferred Provider Organization ("PPO") plans, including proposals based on its current PPO plans. The EUTF's current PPO plans are briefly described below and are more fully described in Appendix M. In addition, the EUTF currently offers two dual-coverage plans to active employees; they are described only in Appendix M. The EUTF is requesting a proposal only for the dual-coverage plan design currently offered by HMSA. Additional plan designs for which quotes are requested are described briefly below.

Without limiting the foregoing, the EUTF also is requesting proposals for plans designed to supplement TRICARE. Furthermore, the EUTF is requesting proposals for high deductible health plans (HDHPs) compatible with Health Savings Accounts (HSAs). The EUTF does not anticipate making contributions to HSAs, but may offer an HDHP that would allow participants to independently set up their own HSAs. However, offerors are free to submit proposals for HDHPs packaged with HSAs.

In order to quote on any of these plans, an offeror must complete the General Questionnaire, the PPO/Dual Coverage/TRICARE Supplement/High Deductible Health Plan Questionnaire, and the appropriate rate proposal forms. Refer to this Appendix and identify the plan design(s) you are quoting.

Each offeror is free to quote on any additional plan designs or bundled packages it wishes to submit for consideration. If the offeror is not proposing any PPO plans, this portion of the RFP can be ignored and no PPO rate proposal forms need to be submitted.

	Current Active PPO Plan Design		**Current Retiree PPO Plan Design**	
	Par	Nonpar	Par	Nonpar
Annual Deductible (per person)	None	$100	None	$100
Family Deductible	None	$300	None	$300
Lifetime Maximum	$2,000,000		$2,000,000	
Maximum Annual Copayment (per person)	$1,500		$2,500	
Family Maximum	$4,500		$7,500	
Office Visits	10%	30%	10%	30%
Well Baby Care	No Charge	No Charge	No Charge	No Charge
Immunizations (includes Hepatitis B)	10%	30%	10%	30%
Hospital	10%	30%	10%	30%
X-ray & Lab Outpatient	10%	30%	10%	30%
Surgery	10%	30%	10%	30%
Emergency Room	10%	30%	10%	30%
Outpatient Surgical Centers	10%	30%	10%	30%
Skilled Nursing Facility	10%	30%	10%	30%
Behavioral Health (Mental Health & Substance Abuse) Physician Visits	10%	10%	10%	30%
Inpatient Behavioral Health Days per CY	30		30	
Outpatient Rehabilitative Services	10%	10%	20%	30%
Durable Medical Equipment	10%	10%	20%	30%

	Active Alternative PPO Plan Design 1	
	Par	Nonpar
Annual Deductible (per person)	None	$100
Family Deductible	None	$300
Lifetime Maximum	Unlimited	
Maximum Annual Co-payment (per person)	$2,500	
Family Maximum	$7,500	
Office Visits	$10	30%
Well Baby Care	No Charge	30%
Immunizations (includes Hepatitis B)	No Charge	No Charge
Hospital	10%	30%
X-ray & Lab Outpatient	10%	30%
Surgery	10%	30%
Emergency Room	$50	$50
Outpatient Surgical Centers	10%	30%
Skilled Nursing Facility	10%	30%
Behavioral Health (Mental Health & Substance Abuse) Physician Visits	$10	30%
Inpatient Behavioral Health Days per CY	30	
Outpatient Rehabilitative Services	10%	30%
Durable Medical Equipment	10%	30%

A. General

1. Include a detailed list of the covered expenses and exclusions that differ from the following lists. Also please identify any covered services that have limitations.

Covered Expenses

Preventive Services
- Newborn and well-baby care
- Immunizations
- One routine office visit/exam per year
- Routine well-woman exam
- Routine pap smear
- Routine mammogram
- Prostate screening
- Colorectal screening

Testing
- Allergy testing
- Diagnostic laboratory and pathology
- Radiology, CT scans, ultrasound and nuclear medicine

Chemotherapy and Radiation Therapy

Hospital and Facility Services
- Ambulatory surgical center
- Emergency room
- Outpatient hospital ancillary services
- Inpatient hospital room and board
- Inpatient anesthesia services
- Skilled nursing facility
- Birthing center

Physician Services
- Office, hospital and emergency room visits
- Consultations
- Routine obstetrical care
- Surgeon, assistant surgeon and anesthesia
- Physician Assistants, Nurse Midwives, etc. working under the direct supervision of a physician

Other Services
- Ambulance
- Appliances, braces, etc.
- Behavioral health services (in and outpatient)
- Cardiac Rehabilitation (short-term)
- Dialysis and related supplies
- Durable medical equipment
- Home therapies and health care
- Hospice care
- Inhalation (or respiratory) therapy
- Injections
- Physical therapy
- Prosthetics
- Speech therapy
- Tissue and organ transplants

<u>Exclusions</u>

Alternative Medical Services [such as:]
- Aromatherapy
- Behavior testing
- Hypnotherapy
- Massage therapy
- Naturopathy
- Rest cure
- Sleep therapy

Artificial Aids
- Eyeglasses
- Corrective lenses
- Hearing aids

Counseling
- Bereavement

- Genetic
- Sexual Identification

Dental Care Services

Disposable take home supplies

Fertility/Infertility
- Reversal of voluntary sterilization
- Cost of storing or processing sperm
- Charges for donor sperm or ova

Services for Which the Patient Has No Responsibility to Pay Due to
- Military or service-related condition
- Workers' Compensation liability

Physical Examinations Related to
- Employment
- Insurance
- Licensing
- Court-order such as parole or probation

Provider is an Immediate Family Member

Transplants
- Services for or transportation of a living donor
- Mechanical or non-human organs
- Organ purchase

Miscellaneous Exclusions
- Acupuncture
- Biofeedback
- Bionic devices
- Blood or blood products
- Complications of a non-covered procedure
- Cosmetic surgery
- Custodial care
- Experimental or investigational services
- Eye exams for contacts, eye exercises
- Hair loss
- Homemaker services
- Lasik Surgery
- Motor vehicles
- Oral travel immunizations
- Personal convenience items
- Photo-refractive keratectomy
- Radial keratotomy
- Routine foot care (unless medically necessary, e.g., diabetic)
- Self-help or self-cure
- Services not medically necessary
- Sexual transformation or gender reassignment

Stand-by time
Travel and lodging cost
Weight reduction programs
Wigs

B. Provider Networks

2. Submit a zip code match using the following parameters:

   - Open provider practices only
   - Two providers within 8 miles and 15 miles

3. Provide a list of hospitals (in alphabetical order) with whom you contract. Indicate which hospitals, if any, are Centers of Excellence and what the specialty is.

4. Complete the following tables as of September 1, 2006:

City and County of Honolulu (Oahu)						
	General Practice	**Family Practice**	**OBGYN**	**Internists**	**Pediatricians**	**Specialists**
Number of Providers						
% Turnover in 2005						

County of Hawaii						
	General Practice	**Family Practice**	**OBGYN**	**Internists**	**Pediatricians**	**Specialists**
Number of Providers						
% Turnover in 2005						

County of Maui						
	General Practice	**Family Practice**	**OBGYN**	**Internists**	**Pediatricians**	**Specialists**
Number of Providers						
% Turnover in 2005						

County of Kauai						
	General Practice	**Family Practice**	**OBGYN**	**Internists**	**Pediatricians**	**Specialists**
Number of Providers						
% Turnover in 2005						

5. What characteristics distinguish your hospital network?

6. Describe the general credentialing process and minimum criteria for a hospital to be a network provider. Include the minimum amount of malpractice coverage per hospital, per occurrence.

7. Describe the re-credentialing process, include timing and percentage of hospitals that are re-credentialed each year. How many years is a hospital contract is in effect?

8. What characteristics distinguish your physician network?

9. Describe the general credentialing process and minimum criteria for a physician to be a network provider. Include the minimum required malpractice coverage per individual practitioner, per occurrence. If the process differs by type of provider (i.e., primary care vs. specialists), please indicate and describe separately.

10. Describe the re-credentialing process; include timing and percentage of physicians that are re-credentialed each year. Provide the number of years that a physician contract is in effect.

11. Provide the number of participating physicians that were terminated in the past 12 months:

Reason for Terminating Broad Categories	**Number of Terminations Initiated by the Physician**	**Number of Terminations Initiated by the Plan**
Quality concerns/patient complaints		
Moved out of service area		N/A
Retirement or death		N/A
Other:		

12. Are there any areas of the State that are not covered by your provider network? Do you anticipate any changes in your service area during the contract term?

13. How often are provider directories updated and mailed to plan members?

14. Do you provide support services for selecting or locating network physicians? How do you respond to members' questions about a provider's credentials?

15. Do you provide on-line access to network provider listings and locations?

C. Health Care Cost Management Programs

16. Describe your organization's pre-admission hospital review program. Please include in your description:

    - Whether you use internal staff or an external organization.
    - Location of review staff.
    - Size and experience of review staff.
    - Employee and physician responsibilities.
    - Who developed the criteria you use for approving hospitalization and/or length of stay?
    - The hours of operation and the time zone, such as 9 to 5 HST.

17. Does your pre-admission review procedure vary for behavioral and substance abuse problems? Please describe the variances and address all the items in the previous question.

18. Please describe your case management procedures.

19. What other utilization management procedures do you have in place?

20. At what point are pre-certification, second surgical opinion and large case management cases referred to physicians for review?

21. Provide the percentage of in-take telephone calls handled directly by Registered Nurses (RNs), License Practitioners (LPNs), other clinically trained personnel and non-clinically trained personnel.

22. In what form and how quickly is notification of utilization review provided to the attending physician, hospital, patient, claim administrator and client?

23. What is your typical turnaround time for your pre-certification service (from the time a call is initiated by the plan participant or provider to the time a phone determination is given and written confirmation is released)?

24. What criteria are used to identify cases for medical case management? If a list is used, please provide a copy of the list. When and how is case management initiated?

25. How and when are medical specialists involved in the case management process?

26. Briefly explain any financial incentives established for providers to comply with utilization management protocols or treatment benchmarks. Include withholds, bonuses or other arrangements that are tied directly to provider utilization results and/or outcomes.

27. Explain any contractual relationships with outpatient facilities such as imaging centers, surgical centers, and laboratories. Are referrals restricted to contracted facilities only? What utilization controls are in place with these facilities to reduce the number of unnecessary services being performed?

D. Quality Assurance

28. Describe the procedures in place to monitor or verify the quality of care being rendered by network providers.

29. Summarize the quality improvement activities your organization completed in the past two years. Describe the most important actions your plan has taken in the past year, based on these studies, to improve performance.

30. Describe any disease management programs that you currently offer and any costs not included in insurance rates or administrative service fees. Also, describe any programs currently under development.

31. Describe the patient appeals policy and process.

E. Customer Service

32. What are the hours of operation and the time zone, such as 9 to 5 HST?

33. What statistics do you generate with respect to telephone response time, abandonment rates, etc.? Can those statistics be segregated by group?

34. Will dedicated customer service representatives be assigned to this account? If yes, how many? Are customer service representatives separate from the claim processing unit, or do claim processors have customer service responsibilities? Do customer service representatives have on-line access to up-to-date eligibility information?

35. Is there a toll-free number available (both locally and on the mainland) to the plan sponsor and participants to handle service issues? What hours will the telephone lines be staffed by a "live" customer service representative? What is the average length of time a member is put on hold before discussing their concern with a customer service representative?

36. Describe any special programs you can provide to plan members who speak a foreign language as their primary language. Be sure to indicate any additional costs for these special programs.

F. Claim Processing

37. Describe the parameters that you have established in your claims processing for acceptable levels of procedural errors, monetary errors and any other kind of error that you measure.

38. What are the accuracy measures that you normally use in auditing claims?

39. Does your computer system have the capability to recognize unbundled charges? If so, please describe.

40. Describe your eligibility system. How do you reconcile problems?

41. How are network providers' reimbursements determined?

42. Do you use reasonable and customary (R&C) fee determinations to pay non-PPO providers? If so, please answer the following questions:

    a. What data are used to determine your R&C profiles? If you purchase a database, is your own data merged with it, and if so, how frequently do you merge it?

    b. How often are your R&C profiles updated?

    c. Do you use precise R&C or do you round off? Please describe your procedure.

43. If participants are traveling out of State or in a foreign country, what coverage do you provide?

44. Where will the EUTF's claims be processed?

    Years this claim office has been in operation _____

    Staffing:

	Number of	**Average Years Experience**	**Turnover Rate in Past 12 Months**
Processors			
Supervisors			
Managers			
Licensed health professionals			

    Annual Claim Volume _____ (number of claims)

    # of Claims/Processor/Day _____

45. How many claim adjustors will be dedicated/assigned to this account? What is the average number of years of experience of these claim adjustors? If your firm is selected, do you anticipate hiring additional claim adjustors? If so, how many?

46. Describe the training received by claim processors, supervisors and other management staff.

47. What distinguishes your claim office's capabilities and performance?

48. In 2005 what percent of claims were processed within 10 calendar days? In 2006, year to date?

49. In 2005 what percent of claims were processed within 30 calendar days? In 2006, year to date?

50. Describe how network hospitals are reimbursed. If reimbursement varies by geographic location, identify reimbursement arrangements by area for those relevant to the EUTF.

51. Are there financial incentives for network hospitals that are tied to utilization goals, readmission rates, quality of care outcomes or other performance results? If so, please explain.

52. Is the facility at risk for cost incurred in excess of the negotiated charge?

53. Do you send patients outside of their community for special care when similar care is available locally? If so, what provisions are made for accommodating family members?

54. When participant coinsurance exists for discounted plans, are providers obligated to limit their charge to participants to the coinsurance percentage of the discounted charge?

55. Describe the appeal procedures in place for plan participants. What is your response time goal to respond to questions and complaints?

HMO QUESTIONNAIRE

The EUTF is requesting quotes for the EUTF's current HMO plan bundled with prescription drug coverage as described in Appendix M. The proposed plan designs should be the same for actives and retirees without Medicare. The EUTF also is soliciting proposals for HMOs for Retirees with Medicare. Provide plan design details if you are proposing a Medicare HMO.

Each offeror is free to quote on any additional HMO plan designs or bundled packages it wishes to submit for consideration. If the offeror is not proposing any HMO plans, this portion of the RFP can be ignored and no HMO rate proposal forms need to be submitted.

General

1. What coverages are included under the plan proposed? Please include a detailed list of the covered expenses and exclusions that differ from the following lists. Also please identify any covered services that have limitations.

   Covered Expenses

   Preventive Services
   - Newborn and well-baby care
   - Immunizations
   - One routine office visit/exam per year
   - Routine well-woman exam
   - Routine pap smear
   - Routine mammogram
   - Prostate screening
   - Colorectal screening

   Testing
   - Allergy testing
   - Diagnostic laboratory and pathology
   - Radiology, CT scans, ultrasound and nuclear medicine

   Chemotherapy and Radiation Therapy

   Hospital and Facility Services
   - Ambulatory surgical center
   - Emergency room
   - Outpatient hospital ancillary services
   - Inpatient hospital room and board
   - Inpatient anesthesia services
   - Skilled nursing facility
   - Birthing center

   Physician Services
   - Office, hospital and emergency room visits
   - Consultations
   - Routine obstetrical care
   - Surgeon, assistant surgeon and anesthesia

Physician Assistants, Nurse Midwives, etc. working under the direct supervision of a physician

Other Services
- Ambulance
- Appliances, braces, etc.
- Behavioral health services (in and outpatient)
- Cardiac Rehabilitation (short-term)
- Dialysis and related supplies
- Durable medical equipment
- Home therapies and health care
- Hospice care
- Inhalation (or respiratory) therapy
- Injections
- Physical therapy
- Prosthetics
- Speech therapy
- Tissue and organ transplants

Exclusions

Alternative Medical Services [such as:]
- Aromatherapy
- Behavior testing
- Hypnotherapy
- Massage therapy
- Naturopathy
- Rest cure
- Sleep therapy

Artificial Aids
- Eyeglasses
- Corrective lenses
- Hearing aids

Counseling
- Bereavement
- Genetic
- Sexual Identification

Dental Care Services

Disposable take home supplies

Fertility/Infertility
- Reversal of voluntary sterilization
- Cost of storing or processing sperm
- Charges for donor sperm or ova

Services for Which the Patient Has No Responsibility to Pay Due to
- Military or service-related condition
- Workers' Compensation liability

Physical Examinations Related to
- Employment
- Insurance
- Licensing
- Court-order such as parole or probation

Provider is an Immediate Family Member

Transplants
- Services for or transportation of a living donor
- Mechanical or non-human organs
- Organ purchase

Miscellaneous Exclusions
- Acupuncture
- Biofeedback
- Bionic devices
- Blood or blood products
- Cosmetic surgery
- Complications of a non-covered procedure
- Custodial care
- Experimental or investigational services
- Eye exams for contacts, eye exercises
- Hair loss
- Homemaker services
- Motor vehicles
- Oral travel immunizations
- Personal convenience items
- Photo-refractive keratectomy
- Radial keratotomy
- Routine foot care (unless medically necessary, e.g., diabetic)
- Self-help or self-cure
- Services not medically necessary
- Sexual transformation or gender reassignment
- Stand-by time
- Travel and lodging cost
- Weight reduction programs
- Wigs

Network Quality

2. Please describe your network management process.

3. Is your network mature or are you developing the network in geographic areas where the EUTF has beneficiaries?

4. What are your quality indicators?

5. What is your target mix of primary care providers and specialists?

- How is it determined?
- How do you decide which specialties can be left out of the network?

6. How often do you re-credential physicians?

7. Provide a current provider directory and one from a year ago at this time.

8. Provide the number of participating providers that were terminated in the past 12 months:

Reason for Terminating Broad Categories	Number of Terminations Initiated by the Provider	Number of Terminations Initiated by the Plan
Quality concerns/patient complaints		
Moved out of service area		N/A
Retirement or death		N/A
Other:		

9. How many participating providers did you have 12 months ago?

Network Development

10. Provide a list of hospitals (in alphabetical order) with whom you contract. Indicate which hospitals, if any, are Centers of Excellence and what the specialty is.

11. What characteristics distinguish your hospital network?

12. Describe the general credentialing process and minimum criteria for a hospital to be a network provider. Include the minimum amount of malpractice coverage per hospital, per occurrence.

13. Describe the re-credentialing process, include timing and percentage of hospitals that are re-credentialed each year. How many years is a hospital contract is in effect?

14. Describe your physician recruitment efforts and the roles played by:

    - location,
    - extended hours,
    - quality indicators and
    - practice patterns.

15. How do you respond to a physician who wants to join the network but has undesirable practice patterns?

16. Describe your credentialing process. Be sure to include a description of the assessment and importance of such factors as the following:

- education,
- training,
- licensing,
- hospital privileges,
- malpractice history,
- disciplinary actions,
- other assessments of ability and
- accreditation of facilities.

Quality of Care

17. Describe the preventive services you offer.

18. Does your organization offer a prenatal program? If so, please describe it.

19. Do you cover blood tests for prostate cancer for non-symptomatic men? If yes, at what age?

20. Does your organization offer telephone-based health information inquiry services? If so, please describe them.

21. Describe your procedures for measuring, improving and assuring quality of care. Do you compile physician profiles? Do you analyze trends in practice patterns? Do you conduct retrospective quality reviews? Have you conducted focused audits on any types of services? Please describe whichever steps the network has taken and what you do with this information.

22. Describe any actions you are taking to improve health care decision making. Please include descriptions of how any guidelines, protocols or decision logic systems are developed, reviewed and enforces.

23. Describe any disease management programs that you currently have. Also, describe any programs currently under development.

24. What types of training and/or education does the network provide to its physicians?

25. Describe your organization's technical assessment programs. (Programs designed to make new treatments available as soon as appropriate and to prevent unproven or ineffective ones from being covered.)

26. Are treatments that still are investigational, but show promise of being effective for a particular disease, eligible for coverage by your company? If yes, how are these cases handled?

27. What are the most frequently requested procedures presently being denied on the basis of "experimental/investigative" or "not medically necessary" exclusions?

28. Does your organization utilize centers of excellence? If yes, how many do you have and where are they located?

29. How are these centers accessed by the plan members?

30. Do you measure outcomes?

    - To what extent?
    - How?

31. Describe your appeal procedures.

32. How are patient complaints about providers handled?

Network Access

33. What are your standards for physician availability? How quickly should a patient be able to see the doctor for:

    - a routine physical,
    - a minor problem,
    - an acute illness and
    - an emergency?

34. How do you monitor compliance with these time frames?

35. How does a member go about changing primary care physicians (PCP)?

36. Can pediatricians and gynecologists be PCPs?

37. Describe your referral process and the typical length of time between an appointment with a primary care physician and approval of the referral.

38. Do you have any category of referrals that are automatically approved? If yes, what are they?

39. Can a member get a second opinion outside of the Independence Practice Association (IPA) or medical group?

40. What are the criteria or processes for getting a referral to a specialist outside of the medical group/IPA or plan?

41. Do you delegate the referral process to IPAs? If so, what percentage of members are enrolled in IPAs with delegated review?

42. How do you monitor physicians closing their practices to managed patients?

43. Do you have a target proportion of a physician's practice that you want your patients to represent? If so, how do you monitor this?

44. If participants are traveling or working in outlying areas, please describe coverage for care they receive there.

45. If participants are traveling out of State or in a foreign country, what coverage do they have?

46. Describe available coverage, if any, for dependents living outside your service area.

47. How do you handle referrals to specialists on other islands, such as Oahu? Do you cover travel expenses? If so, what expenses are covered (e.g., air fare only, air fare plus lodging, etc.)? Are the expenses of a companion covered?

Customer Service

48. Is there a toll-free number available (both locally and on the mainland) to the plan sponsor and participants to handle service issues? What hours will the telephone lines be staffed by a "live" customer service representative? What is the average length of time a member is put on hold before discussing their concern with a customer service representative?

49. Describe your customer service and member relations functions.

50. What standards are in place to measure customer service quality and how are they monitored?

51. Do you measure patient satisfaction?

    - How?
    - What have the results been?

52. Do you provide on-line access to network provider listings and locations?

Cost Controls

53. Do you have documented criteria for authorizing inpatient treatment?

    - Who has copies?
    - How frequently are the criteria reviewed and updated?
    - What happens when a request cannot be approved on the basis of the criteria?
    - In what percentage of the requests received in 2005 was the treatment redirected?

54. What outpatient treatments or procedures require authorization?

    - Do you have documented criteria for authorizing these?
    - Are alternatives suggested?
    - How many were redirected in 2005?

55. Do you delegate utilization management to IPAs? If so, do you expect them to use your criteria? How do you monitor them?

56. Provide a list of hospitals (in alphabetical order) with whom you contract. Indicate which hospitals, if any, are Centers of Excellence and what the specialty is.

Tables

57. Complete the following tables as of July 1, 2006:

City and County of Honolulu (Oahu)						
	General Practice	**Family Practice**	**OBGYN**	**Internists**	**Pediatricians**	**Specialists**
Number of Providers						
% Turnover in 2005						

County of Hawaii						
	General Practice	**Family Practice**	**OBGYN**	**Internists**	**Pediatricians**	**Specialists**
Number of Providers						
% Turnover in 2005						

County of Maui						
	General Practice	**Family Practice**	**OBGYN**	**Internists**	**Pediatricians**	**Specialists**
Number of Providers						
% Turnover in 2005						

County of Kauai						
	General Practice	**Family Practice**	**OBGYN**	**Internists**	**Pediatricians**	**Specialists**
Number of Providers						
% Turnover in 2005						

Claim Processing

58. Describe your procedures for handling claims for services rendered by non-network providers. Please differentiate between emergency services and non-emergency services.

59. What are your quality assurance procedures with regard to processing non-network claims?

60. Do you coordinate benefits?

61. In 2005 what percent of non-network claims were processed within 10 calendar days? In 2006, year to date?

62. In 2005 what percent of non-network claims were processed within 30 calendar days? In 2006, year to date?

PRESCRIPTION DRUG PLAN QUESTIONNAIRE

The EUTF is requesting quotes for the current prescription drug plans, offered by HMSA including the stand-alone prescription drug plan, as well as two additional plan designs. The EUTF would like these prescription drug benefits quoted both on a bundled and an unbundled basis with the PPO. The current plans are described briefly below and more fully in Appendix M. The two additional plan designs are described briefly below. The EUTF also is requesting quotes for a Medicare Part D prescription drug plan to be effective January 1, 2008. In order to quote on the prescription drug plan(s), an offeror must complete the General Questionnaire, the Prescription Drug Questionnaire and the prescription drug rate proposal forms.

Each offeror is free to quote on any additional prescription drug plan designs or bundled packages it wishes to submit for consideration. If the offeror is not proposing any prescription drug plans, this portion of the RFP can be ignored and no prescription drug rate proposal forms need to be submitted.

If a contract is awarded to an offeror for both medical and prescription drug plans, annual accountings can be combined, where a surplus in one plan can be used to offset a deficit in the other.

	Current Active & Retiree Prescription Drug Plan Design With PPO Plan or Stand-alone
Retail	
Generic	$5
Preferred Brand	$15
Other Brand	$30
Mail Order	
Generic	$10
Preferred Brand	$35
Other Brand	$60

	Prescription Drug Plan Design 1 With PPO Plan or Stand-alone
Retail	
Generic	$5
Preferred Brand	$20
Other Brand	100% of remaining eligible charge after $20 member co-payment and differential
Mail Order	
Generic	$10
Preferred Brand	$45
Other Brand	Not Available

Plan Design 2 is a coinsurance plan with a 90% Benefit

	Plan Design 2
Retail	
Generic	90%
Preferred Brand	90%
Other Brand	90%
Mail Order	
Generic	90%
Preferred Brand	90%
Other Brand	90%

A. General

1. Include a detailed list of the exclusions that differ from the following list. Also please identify any covered services that have limitations.

Exclusions
- Immunization Agents
- Agents Used in Skin Tests for Allergies
- Drugs Dispensed to Inpatients
- Convenience Packaged Drugs
- Unit Dose Drugs
- Drugs That Do Not Require Prescription
- Drugs Used Primarily for Cosmetic Purposes
- Drugs to Enhance Athletic Performance
- Injectable Travel Immunizations
- Reusable Devices
- Drugs Associated with Services Excluded Under the HMO Plan

B. Provider Networks

2. Complete the following table:

	City and County of Honolulu (Oahu)		**County of Hawaii**	
	Chain Drug Stores	**Independent Pharmacies**	**Chain Drug Stores**	**Independent Pharmacies**
Number of Pharmacies				
% Turnover in 2005				
	County of Maui		**County of Kauai**	
	Chain Drug Stores	**Independent Pharmacies**	**Chain Drug Stores**	**Independent Pharmacies**
Number of Pharmacies				
% Turnover in 2005				

3. Describe the general credentialing process and minimum criteria for a pharmacy to be a network provider. Include the minimum required malpractice coverage per individual practitioner, per occurrence. If the process differs by type of pharmacy, please indicate and describe separately.

4. Describe the re-credentialing process; include timing and percentage of pharmacies that are re-credentialed each year. Provide the number of years that a pharmacy contract is in effect.

5. Provide the number of participating pharmacies that were terminated in the past 12 months:

Reason for Terminating Broad Categories	**Number of Terminations Initiated by the Pharmacy**	**Number of Terminations Initiated by the Plan**
Quality concerns/patient complaints		
Moved out of service area		N/A
Retirement or death		N/A
Other:		

6. Are there any areas of the State that are not covered by your pharmacy network? Do you anticipate any changes in your service area during the contract term?

7. How often are pharmacy directories updated and mailed to plan participants?

8. Do you provide support services for selecting or locating network pharmacies? How do you respond to questions about a pharmacy's credentials?

9. Do you provide on-line access to network pharmacy listings and locations?

C. Quality Assurance

10. Describe the procedures in place to monitor or verify the quality of care being rendered by network pharmacies.

11. Summarize the quality improvement activities your organization completed in the past two years. Describe the most important actions your plan has taken in the past year, based on these studies, to improve performance.

12. Describe the patient appeals policy and process.

D. Drug Utilization Review (DUR)

13. Describe the utilization review procedures for in-network and out-of-network claims. Describe separately for your retail network and mail order claims. Your answer should address:

Eligibility
Prospective Review
Concurrent and Retroactive Review of on-going treatment
Ability to provide utilization statistics and savings report
DUR staff credentials and qualifications
DUR staff training programs and monitoring
Systems edits and on-line access to supporting information

For each component noted above be sure to provide:

The qualifications of personnel performing the stated task.
The timing requirements of each task.
How standards were developed.
How information is captured and results are monitored.

14. What items are included in your standard automated editing process? What items are reviewed prospectively at point of sale, concurrently, and retroactively?

15. Complete the following table for the retail network:

DUR Edit Criteria	**Standard Edit Criterion? (check if yes)**	**Percent of Pharmacies with On-line access to Edits**
Eligible Drug		
Drug Interactions		
Duplicate Prescription		
Refill too Soon		
Proper Dosage		
Proper Days Supply		
Generic Availability		
Other (List)		

16. Complete the following table for mail order processing:

DUR Edit Criteria	Standard Edit Criterion? (check if yes)
Eligible Drug	
Drug Interactions	
Duplicate Prescription	
Refill too Soon	
Proper Dosage	
Proper Days Supply	
Generic Availability	
Other (List)	

17. What percentage of telephone calls are handled directly by Registered Pharmacists (RPhs), other clinically trained personnel, and non-clinically trained personnel?

18. What is the expected percentage of total prescription plan cost savings that will result from the implementation of your DUR program?

19. Do you monitor high cost claimants? What criteria are used to identify high cost claimants and what steps are taken to manage a claimant's compliance with therapy?

20. Briefly explain any financial incentives established for pharmacies to comply with utilization management protocols or treatment benchmarks. Include withholds, bonuses or other arrangements that are tied directly to provider utilization results and/or outcomes.

21. Describe your patient and pharmacist education efforts. Include sample materials.

22. How do you guard against the filling of separate prescriptions for the same or similar drugs at different pharmacies on the same day? Within five days after the initial fill?

23. Do you evaluate the appropriateness of the prescribing physician/practitioner credentials? How do you compare the prescribing physician's/practitioner's qualifications with the type of prescription written?

E. Customer Service

24. What statistics do you generate with respect to telephone response time, abandonment rates, etc.? Can those statistics be segregated by group?

25. Will dedicated customer service representatives be assigned to this account? If yes, how many? Are customer service representatives separate from the claim processing unit, or do claim processors have customer service responsibilities? Do customer service representatives have on-line access to up-to-date eligibility information?

26. What is the toll-free number available (both locally and on the mainland) to the plan sponsor and participants to handle service issues? What hours will the telephone lines be staffed by a "live" customer service representative? What is the average length of time a member is put on hold before discussing their concern with a customer service representative?

27. Describe any special programs you can provide to plan members who speak a foreign language as their primary language. Be sure to indicate any additional costs for these special programs.

F. Claim Processing

28. What percentage of your prescription drug claims are adjudicated at the point-of-sale?

29. Describe your eligibility system. How do you reconcile problems?

30. How are network pharmacy reimbursements determined?

31. How are non-network pharmacy reimbursements determined?

32. If participants are traveling out of State or in a foreign country, what coverage do they have?

33. Do you coordinate benefits? How is this accomplished at point-of-sale?

34. When participant coinsurance exists for discounted plans, are providers obligated to limit their charge to participants to the coinsurance percentage of the discounted charge?

35. Describe the appeal procedures in place for plan participants. What is your response time goal to respond to questions and complaints?

G. Prescription Drug Reimbursement

36. Will you agree to pass-through pricing? That is, will you charge precisely what the PBM reimburses retail pharmacies to dispense drugs or what the PBM pays to purchase drugs for its mail-order pharmacy? Will you also agree to minimum price guarantees?

37. Indicate if all of your network pharmacy contracts will include the "lesser of retail price, maximum allowable cost (MAC) price or discounted price" provision. How do you determine that plan members always receive this lowest price? What

procedures are established to ensure that the pharmacy is in compliance with this provision?

38. Describe your MAC program for generic substitution. Do you offer voluntary, mandatory or incentive-based MAC programs? Describe how patients are informed about and impacted by such programs.

39. What is your generic substitution rate and the percent of total generic drugs dispensed for your Voluntary MAC, Incentive-Based MAC, and Mandatory MAC programs? Your answer should be based on your latest experience for similar plan designs and locations.

	Substitution Percentage	**Percent of Total Rx's Dispensed**
Voluntary MAC		
Incentive-Based MAC		
Mandatory MAC		

40. Based on your latest data available, what net savings, relative to no MAC in place, would you expect the client to achieve from the following (express as a percent of total expected Rx costs):

	Percentage Savings
Voluntary MAC	
Incentive-Based MAC	
Mandatory MAC	

41. Will you pass through all manufacturer payments and all payments from other third parties? Will you disclose all contracts with all manufacturers and all other third parties?

42. For the following therapeutic categories provide the average discounted ingredient cost per 100 units for your book of business, based on your current formulary drugs and contractual prices:

Indicate year: _____

Therapeutic Class	Percentage of All Rx Costs	Average Formulary Cost*/100 Units	Name of Drugs on Formulary And Manufacturer
Antidepressants			
Angiotensin-Converting Enzyme (ACE) Inhibitors			
Antiulcer Preps			
Antiarthritic			
Cephalosporin			
Antiinflammatory - Non - Steroidal			
Antihistamines			
Calcium Channel Blockers			
Cholesterol Reducers			
Hypotensive			

* Actual cost excludes dispensing fees and before any co-payments/deductibles are applied.

43. Do you have an open or closed formulary? If closed, describe your procedures if a physician believes a non-formulary drug is necessary.

44. Provide a sample listing of formulary drugs.

45. How do you make physicians aware of your formulary?

46. Describe how network pharmacies are reimbursed. Your answer should be consistent with the fees provided in the financial section of this bid specification. Include any incentive based dispensing fees, bonuses, withholds, retroactive capitations, etc.

47. Describe how out-of-network providers are reimbursed. Do you determine and define a "R&C" charge for medications for out-of-network pharmacies?

48. How often are network ingredient costs, dispensing fees, capitations and out-of-network allowances updated?

49. Are there financial incentives to network pharmacies that are tied to utilization rates, compliance goals, quality of care outcomes or other performance results? If so, please explain.

50. Describe how you handle specialty drugs, such as injectables.

CHIROPRACTIC BENEFITS QUESTIONNAIRE

The EUTF is requesting quotes for the EUTF's current chiropractic plan as described in Appendix M. Each offeror is free to quote on any additional chiropractic plan designs or bundled packages it wishes to submit for consideration. If the offeror is not proposing any chiropractic plans, this portion of the RFP can be ignored and no chiropractic rate proposal forms need to be submitted.

General

1. What benefits are included in the proposed plan? Please detail any limitations and exclusions.

Network Quality

2. What characteristics distinguish your chiropractic network?

3. How do you respond to a chiropractor who wants to join the network but has undesirable practice patterns?

4. Describe the general credentialing process and minimum criteria for a chiropractor to be a network provider. Include the minimum required malpractice coverage per individual practitioner, per occurrence.

5. Describe the re-credentialing process; include timing and percentage of chiropractors that are re-credentialed each year. Provide the number of years that a chiropractic contract is in effect.

6. Provide the number of participating chiropractors that were terminated in the past 12 months:

Reason for Terminating Broad Categories	**Number of Terminations Initiated by the Chiropractors**	**Number of Terminations Initiated by the Plan**
Quality concerns/patient complaints		
Moved out of service area		N/A
Retirement or death		N/A
Other:		

7. Are there any areas of the State that are not covered by your provider network? Do you anticipate any changes in your service area during the contract term?

8. How often are chiropractic directories updated and mailed to plan members?

9. Do you provide support services for selecting or locating network chiropractors? How do you respond to members' questions about a chiropractor's credentials?

10. Do you provide on-line access to network provider listings and locations?

Quality of Care

11. What utilization management procedures do you have in place?

12. Describe the procedures in place to monitor or verify the quality of care being rendered by network chiropractors.

13. Summarize the quality improvement activities your organization completed in the past two years. Describe the most important actions your plan has taken in the past year, based on these studies, to improve performance.

14. Describe the patient appeals policy and process.

Customer Service

15 What are the hours of operation and the time zone, such as 9 to 5 HST?

16. What statistics do you generate with respect to telephone response time, abandonment rates, etc.? Can those statistics be segregated by group?

17. Will dedicated customer service representatives be assigned to this account? If yes, how many? Are customer service representatives separate from the claim processing unit, or do claim processors have customer service responsibilities? Do customer service representatives have on-line access to up-to-date eligibility information?

18. Is there a toll-free number available to the plan sponsor and participants to handle service issues? What hours will the telephone lines be staffed by a "live" customer service representative? What is the average length of time a member is put on hold before discussing their concern with a customer service representative?

19. Describe any special programs you can provide to plan members who speak a foreign language as their primary language. Be sure to indicate any additional costs for these special programs.

Claim Processing

If the claim office handling chiropractic claims is not the same as the one described in the HMO or PPO plan section, please answer the following questions:

20. Describe the parameters that you have established in your claims processing for acceptable levels of procedural errors, monetary errors and any other kind of error that you measure.

21. What are the accuracy measures that you normally use in auditing claims?

22. Does your computer system have the capability to recognize unbundled charges? If so, please describe.

23. Please describe your eligibility system. How do you reconcile problems? Can you accept dependent names?

24. How are network chiropractic reimbursements determined?

25. Do you use R&C to pay non-network chiropractors? If so, please answer the following questions. If not, how do you pay them?

    a. What data are used to determine your R&C profiles? If you purchase a database, is your own data merged with it, and if so, how frequently do you merge it?

    b. How often are your R&C profiles updated?

    c. Do you use precise R&C or do you round off? Please describe your procedure.

26. If participants are traveling out of State or in a foreign country, what coverage do they have? Describe available coverage, if any, for dependents living outside your service area.

27. Do you coordinate benefits?

28. Where will the EUTF's claims be processed?

    Years this claim office has been in operation _____

    Staffing:

	Number of	**Average Years Experience**	**Turnover Rate in Past 12 Months**
Processors			
Supervisors			
Managers			
Licensed health professionals			

    Annual Claim Volume _____ (number of claims)

    # of Claims/Processor/Day _____

29. How many claim adjustors will be dedicated/assigned to this account? What is the average number of years of experience of these claim adjustors? If your firm is selected, do you anticipate hiring additional claim adjustors? If so, how many?

30. Describe the training received by claim processors, supervisors and other management staff.

31. What distinguishes your claim office's capabilities and performance?

32. In 2005 what percent of claims were processed within 10 calendar days? In 2006, year to date?

33. In 2005 what percent of claims were processed within 30 calendar days? In 2006, year to date?

34. When participant coinsurance exists for discounted plans, are providers obligated to limit their charge to participants to the coinsurance percentage of the discounted charge?

35. Describe the appeal procedures in place for plan participants. What is your response time goal to respond to questions and complaints?

36. Do you anticipate any changes in your service area during the contract term?

Table

37. Complete the following table as of July 1, 2006:

	County of			
	Honolulu	**Hawaii**	**Maui**	**Kauai**
Number of Network Chiropractors				
% Turnover in 2005				

DENTAL PLAN QUESTIONNAIRE

The EUTF is requesting quotes for the EUTF's current dental plan as described in Appendix M, but not the dual-coverage dental plan. The EUTF is interested in exploring the possibility of converting its dental deductible from a calendar year to a plan year. Please submit a separate rate proposal form if doing so would have an impact on the rates. Each offeror is free to quote on any additional dental plan designs, including prepaid plans or bundled packages it wishes to submit for consideration. If the offeror is not proposing any dental plans, this portion of the RFP can be ignored and no dental rate proposal forms need to be submitted.

Covered Expenses and Exclusions

1. What services are covered under the proposed plan? Provide a copy of all covered procedures using the current dental terminology (CDT)-5 codes and any limitations pertaining to those procedures. Please include a detailed list of the exclusions.

2. Are there any pre-existing condition exclusions?

3. Describe your orthodontia benefits and any limitations.

Provider Networks

4. Complete the following tables as of July 1, 2006:

City and County of Honolulu (Oahu)							
	General Dentists	**Pediatric Dentists**	**Perio-dontists**	**Oral Surgeons**	**Endo-dontists**	**Ortho-dontists**	**Prostho-dontists**
Number of Providers							
% Turnover in 2005							

County of Hawaii							
	General Dentists	**Pediatric Dentists**	**Perio-dontists**	**Oral Surgeons**	**Endo-dontists**	**Ortho-dontists**	**Prostho-dontists**
Number of Providers							
% Turnover in 2005							

County of Maui							
	General Dentists	**Pediatric Dentists**	**Perio-dontists**	**Oral Surgeons**	**Endo-dontists**	**Ortho-dontists**	**Prostho-dontists**
Number of Providers							
% Turnover in 2005							

County of Kauai							
	General Dentists	**Pediatric Dentists**	**Perio-dontists**	**Oral Surgeons**	**Endo-dontists**	**Ortho-dontists**	**Prostho-dontists**
Number of Providers							
% Turnover in 2005							

5. What characteristics distinguish your dental network?

6. Describe the general credentialing process and minimum criteria for a dentist to be a network dentist. Include the minimum required malpractice coverage per individual dentist, per occurrence. If the process differs by specialty, please indicate and describe separately.

7. Describe the re-credentialing process; include timing and percentage of dentists that are re-credentialed each year. Provide the number of years that a dental contract is in effect.

8. Provide the number of participating providers that were terminated in the past 12 months:

Reason for Terminating Broad Categories	Number of Terminations Initiated by the Provider	Number of Terminations Initiated by the Plan
Quality concerns/patient complaints		
Moved out of service area		N/A
Retirement or death		N/A
Other:		

9. Are there any areas of the State that are not covered by your dental network? Do you anticipate any changes in your service area during the contract term?

10. How often are dental directories updated and mailed to plan members?

11. Do you provide member support services for selecting or locating network dentists? How do you respond to questions about a dentist's credentials?

12. Do you provide on-line access to network dentist listings and locations?

Health Care Cost Management Programs

13. What utilization management procedures do you have in place?

14. Do general dentists act as gatekeepers for specialists' service? Describe the referral process. Who is responsible for the cost of specialists (i.e., primary care dentist, your company)?

15. Are there procedures for which preauthorization is required?

16. Is pre-determination of benefits available?

Quality Assurance

17. Describe the procedures in place to monitor or verify the quality of care being rendered by network dentists.

18. Summarize the quality improvement activities your organization completed in the past two years. Describe the most important actions your plan has taken in the past year, based on these studies, to improve performance.

19. Describe the patient appeals policy and process.

Customer Service

20. What are the hours of operation and the time zone, such as 9 to 5 HST?

21. What statistics do you generate with respect to telephone response time, abandonment rates, etc.? Can those statistics be segregated by group?

22. Will dedicated customer service representatives be assigned to this account? If yes, how many? Are customer service representatives separate from the claim processing unit, or do claim processors have customer service responsibilities? Do customer service representatives have on-line access to up-to-date eligibility information?

23. Is there a toll-free number available (both locally and on the mainland) to the plan sponsor and participants to handle service issues? What hours will the telephone lines be staffed by a "live" customer service representative? What is the average length of time a member is put on hold before discussing their concern with a customer service representative?

24. Describe any special programs you can provide to plan members who speak a foreign language as their primary language. Be sure to indicate any additional costs for these special programs.

Claim Processing

25. Describe the parameters that you have established in your claims processing for acceptable levels of procedural errors, monetary errors and any other kind of error that you measure.

26. What are the accuracy measures that you normally use in auditing claims?

27. Does your computer system have the capability to recognize unbundled charges? If so, please describe.

28. Please describe your eligibility system. How do you reconcile problems?

29. How are network dentists' reimbursements determined?

30. Do you use R&C to pay non-PPO dentists? If so, please answer the following questions:

    a. What data are used to determine your R&C profiles? If you purchase a database, is your own data merged with it, and if so, how frequently do you merge it?

    b. How often are your R&C profiles updated?

    c. Do you use precise R&C or do you round off? Please describe your procedure.

31. If participants are traveling out of State or in a foreign country, what coverage do they have? Describe available coverage, if any, for retirees or dependents living outside your service area.

32. Do you coordinate benefits?

33. Where will the EUTF's claims be processed?

    Years this claim office has been in operation _____

    Staffing:

	Number of	Average Years Experience	Turnover Rate in Past 12 Months
Processors			
Supervisors			
Managers			
Licensed health professionals			

    Annual Claim Volume _____ (number of claims)

    # of Claims/Processor/Day _____

34. How many claim adjustors will be dedicated/assigned to this account? What is the average number of years of experience of these claim adjustors? If your firm is selected, do you anticipate hiring additional claim adjustors? If so, how many?

35. Describe the training received by claim processors, supervisors and other management staff.

36. What distinguishes your claim office's capabilities and performance?

37. In 2005 what percent of claims were processed within 10 calendar days? In 2006, year to date?

38. In 2005 what percent of claims were processed within 30 calendar days? In 2006, year to date?

39. When participant coinsurance exists for discounted plans, are providers obligated to limit their charge to participants to the coinsurance percentage of the discounted charge?

40. Describe the appeal procedures in place for plan participants. What is your response time goal to respond to questions and complaints?

VISION PLAN QUESTIONNAIRE

The EUTF is requesting proposals for the EUTF's current vision plan as described in Appendix M, but not the dual-coverage vision plan. Each offeror is free to quote on any additional vision plan designs, such as increased allowances for exams and materials or bundled packages it wishes to submit for consideration. If the offeror is not proposing any vision plans, this portion of the RFP can be ignored and no vision rate proposal forms need to be submitted.

Covered Expenses and Exclusions

1. Provide a detailed list of the covered services, limitations and exclusions in the proposed plan.

2. What types of frames, lenses and contact lenses will be made available to members at discounted prices? Include type of tints, frame materials, custom grinding, scratch resistance lenses, oversized lenses, and any custom finishes or materials used.

3. Are network doctors required to provide members with prescriptions (so they can purchase glasses or contact lenses elsewhere)?

4. What services are covered with respect to the dispensing of frames and lenses?

5. What is the average waiting period between placement of order and delivery of frames and lenses?

6. Are checks made for accuracy and fit?

7. Are any follow up adjustments covered? If so, for how long a period after the frames are dispensed?

8. For how long are the frames and lenses guaranteed?

9. What is your replacement policy for frames and lenses?

10. What services are covered with respect to the dispensing of contact lenses?

11. What is the average waiting period between placement of order and delivery of the contact lenses?

12. What tests and checks are made at time of fitting for contact lenses?

13. Are any follow-up tests covered for contact lenses?

14. If so, for how long a period after the lenses are dispensed?

15. Are instructions provided regarding adequate care, handling, insertion and wearing time of contact lenses?

16. Who is authorized to provide instructions?

17. For how long are the contact lenses guaranteed?

18. What is your replacement policy for contact lenses?

19. Are there any pre-existing condition exclusions?

Provider Networks

20. Complete the following table as of July 1, 2006:

	City and County of Honolulu (Oahu)		**County of Hawaii**	
	Optometrists	**Ophthalmologists**	**Optometrists**	**Ophthalmologists**
Number of Providers				
% Turnover in 2005				
	County of Maui		**County of Kauai**	
	Optometrists	**Ophthalmologists**	**Optometrists**	**Ophthalmologists**
Number of Providers				
% Turnover in 2005				

21. What characteristics distinguish your vision network?

22. Describe the general credentialing process and minimum criteria for a provider to be a network provider. Include the minimum required malpractice coverage per individual practitioner, per occurrence. If the process differs by type of provider, please indicate and describe separately.

23. Describe the re-credentialing process; include timing and percentage of providers that are re-credentialed each year. Provide the number of years that a provider contract is in effect.

24. Provide the number of participating providers that were terminated in the past 12 months:

Reason for Terminating Broad Categories	Number of Terminations Initiated by the Provider	Number of Terminations Initiated by the Plan
Quality concerns/patient complaints		
Moved out of service area		N/A
Retirement or death		N/A
Other:		

25. Are there any areas of the State that are not covered by your provider network? Do you anticipate any changes in you service area during the contract term?

26. How often are provider directories updated and mailed to plan members?

27. Do you provide support services for selecting or locating network providers? How do you respond to members' questions about a provider's credentials?

28. Do you provide on-line access to network provider listings and locations?

Health Care Cost Management Programs

29. What utilization management procedures do you have in place?

Quality Assurance

30. Describe the procedures in place to monitor or verify the quality of care being rendered by network providers.

31. Summarize the quality improvement activities your organization completed in the past two years. Describe the most important actions your plan has taken in the past year, based on these studies, to improve performance.

32. Describe the patient appeals policy and process.

Customer Service

33. What are the hours of operation and the time zone, such as 9 to 5 HST?

34. What statistics do you generate with respect to telephone response time, abandonment rates, etc.? Can those statistics be segregated by group?

35. Will dedicated customer service representatives be assigned to this account? If yes, how many? Are customer service representatives separate from the claim processing unit, or

do claim processors have customer service responsibilities? Do customer service representatives have on-line access to up-to-date eligibility information?

36. Is there a toll-free number available (both locally and on the mainland) to the plan sponsor and participants to handle service issues? What hours will the telephone lines be staffed by a "live" customer service representative? What is the average length of time a member is put on hold before discussing their concern with a customer service representative?

37. Describe any special programs you can provide to plan members who speak a foreign language as their primary language. Be sure to indicate any additional costs for these special programs.

Claim Processing

38. Describe the parameters that you have established in your claims processing for acceptable levels of procedural errors, monetary errors and any other kind of error that you measure.

39. What are the accuracy measures that you normally use in auditing claims?

40. Does your computer system have the capability to recognize unbundled charges? If so, please describe.

41. Please describe your eligibility system. How do you reconcile problems? Can you accept dependent names?

42. How are network providers' reimbursements determined?

43. How are non-network providers' reimbursements determined?

44. If members are traveling out of State or in a foreign country, what coverage do they have? Describe available coverage, if any, for retirees or dependents living outside your service area.

45. Do you coordinate benefits?

46. Where will the EUTF's claims be processed?

Years this claim office has been in operation _____

Staffing:

	Number of	Average Years Experience	Turnover Rate in Past 12 Months
Processors			
Supervisors			
Managers			
Licensed health professionals			

Annual Claim Volume _____ (number of claims)

# of Claims/Processor/Day _____

47. How many claim adjustors will be dedicated/assigned to this account? What is the average number of years of experience of these claim adjustors? If your firm is selected, do you anticipate hiring additional claim adjustors? If so, how many?

48. Describe the training received by claim processors, supervisors and other management staff.

49. What distinguishes your claim office's capabilities and performance?

50. In 2005 what percent of claims were processed within 10 calendar days? In 2006, year to date?

51. In 2005 what percent of claims were processed within 30 calendar days? In 2006, year to date?

52. When participant coinsurance exists for discounted plans, are providers obligated to limit their charge to participants to the coinsurance percentage of the discounted charge?

53. Describe the appeal procedures in place for plan participants. What is your response time goal to respond to questions and complaints?

LIFE INSURANCE QUESTIONAIRE

The EUTF is requesting proposals for life insurance benefits. The EUTF is requesting proposals for as much life insurance as can be purchased for a premium of $4.12 per month per active employee or retiree. If the offeror is not proposing any life insurance plans, this portion of the RFP can be ignored and no life rate proposal forms need to be submitted.

The EUTF has offered $26,000 on active employees and $1,900 on retirees up to June 30, 2006. Benefit amounts were increased to $31,217 on active employees and $2,372 on retirees as of July 1, 2006. Age reductions for active employees are as follows:

Age 65-69	65%
Age 70-74	45%
Age 75-79	30%
Age 80 and Over	20%

In addition, the current plan provides for an accelerated death benefit and conversion on reductions. There is no premium waiver in the current plan. Contractors must waive the actively at work requirement for employees disabled prior to the effective date.

Benefit amounts are requested separately for actives and retirees.

1. As the plan covers death benefits only, with no premium waiver, describe how you will reserve for IBNR. Will you guarantee the factor?

2. What is your retention for the group? State premium tax is 3.5%. State your "all other" retention and delineate the factors that are included in that retention. You must be willing to guarantee your retention.

3. Do you offer an "Accelerated Death Benefit" or "Living Needs" Benefit? If so, please describe. Include the percentage of life amount payable, when it is payable and the cost for this feature if any.

Quality Assurance

4. Describe the appeals policy and process.

Customer Service

5. Will dedicated customer service representatives be assigned to this account? If yes, how many? Are customer service representatives separate from the claim processing unit, or do claim processors have customer service responsibilities? Do customer service representatives have on-line access to up-to-date eligibility information?

6. Is there a toll-free number available (both locally and on the mainland) to the plan sponsor and participants to handle service issues? What hours will the telephone lines be staffed by a "live" customer service representative? What is the average length of time a member is put on hold before discussing their concern with a customer service representative?

7. Describe any special programs you can provide to plan members who speak a foreign language as their primary language. Be sure to indicate any additional costs for these special programs.

Claim Processing

8. Describe the parameters that you have established in your claims processing for acceptable levels of procedural errors, monetary errors and any other kind of error that you measure.

9. What are the accuracy measures that you normally use in auditing claims?

10. Will you accept beneficiary information for the current carrier?

11. Please describe your eligibility system. How do you reconcile problems?

12. Where will the EUTF's claims be processed?

    Years this claim office has been in operation _____

    Staffing:

	Number of	Average Years Experience	Turnover Rate in Past 12 Months
Processors			
Supervisors			
Managers			
Licensed health professionals			

Annual Claim Volume _____ (number of claims)

# of Claims/Processor/Day _____

13. How many claim adjustors will be dedicated/assigned to this account? What is the average number of years of experience of these claim adjustors? If your firm is selected, do you anticipate hiring additional claim adjustors? If so, how many?

14. Describe the training received by claim processors, supervisors and other management staff.

15. What distinguishes your claim office's capabilities and performance?

16. In 2005 what percent of claims were processed within 10 calendar days? In 2006, year to date?

17. In 2005 what percent of claims were processed within 30 calendar days? In 2006, year to date?

18. Describe the appeal procedures in place for plan participants. What is your response time goal to respond to questions and complaints?